EPSTEIN BECKER GREEN | HEALTH CARE & LIFE SCIENCES CLIENT ALERT

Thought Leaders in Health Law®

IRS Issues Proposed Regulations for Section 501(c)(3) Tax-Exempt Hospitals Regarding the Community Health Needs Assessment and Other Requirements of Section 501(r)

by Jay E. Gerzog and Tamar R. Rosenberg

April 2013

On April 5, 2013, the Internal Revenue Service ("IRS") published proposed regulations ("Proposed Regulations") providing guidance regarding certain aspects of Section 501(r) of the Internal Revenue Code ("Code"), which establishes various requirements for hospitals to qualify for federal income tax exemption under Code Section 501(c)(3). Comments are due to the IRS by July 5, 2013. This alert highlights the key issues addressed in the Proposed Regulations, as follows:[1]

1. **Community health needs assessment ("CHNA") and implementation strategy requirements—**every three years, each "hospital facility" must (i) conduct an assessment of the health needs of the community that it serves, taking into account input from persons who represent the broad interests of the community; (ii) adopt an "implementation strategy" to meet the community health needs identified in the CHNA; and (iii) publicize the CHNA;

2. **Hospitals operated by joint ventures—**the circumstances under which a Section 501(c)(3) organization participating in a joint venture that operates a hospital facility (i.e., whole-hospital joint ventures) will itself be treated as subject to Section 501(r); and

3. **Consequences of the failure to comply with the CHNA and other Section 501(r) requirements—**excise taxes, revocation of tax exemption, and tax-exempt bond implications.

Additionally, this alert provides related background information, important deadlines, key observations, and next steps.

[1] The Proposed Regulations also address other more minor or technical aspects of Section 501(r).

I. Background

- **Section 501(r) generally.** Section 501(r) was adopted as part of the Patient Protection and Affordable Care Act of 2010 to establish additional statutory requirements for hospitals to qualify for Section 501(c)(3) tax-exempt status, including requirements regarding:

  - conducting CHNAs;

  - adopting and publicizing financial assistance and emergency care policies;

  - limiting amounts charged by a hospital for emergency or other medically necessary care provided to individuals eligible for financial assistance to not more than the amounts generally billed to insured patients, and prohibiting the use of gross charges; and

  - prohibiting a hospital from engaging in extraordinary collection actions before making reasonable efforts to determine whether the individual is eligible for financial assistance.

- **Previous IRS guidance on Section 501(r).** The Proposed Regulations update IRS guidance published in July 2011 regarding CHNAs (Notice 2011-52). The Proposed Regulations generally do not specifically address the non-CHNA requirements under Section 501(r). Such non-CHNA requirements were the subject of proposed regulations issued in June 2012.

II. Important Deadlines

- **Initial CHNA deadline.** The first deadline for the CHNA requirements is generally that a hospital facility must have conducted a CHNA and its governing board must have adopted a CHNA report and implementation strategy by the end of the hospital facility's first tax year that begins after March 23, 2012 (e.g., December 31, 2013, for calendar-year organizations). The implementation strategy is generally required to be adopted in the same tax year in which the CHNA is conducted. If, however, the Proposed Regulations become final, the deadline for the board to adopt an implementation strategy would be extended to four-and-a-half months after such tax year-end (e.g., May 15, 2014, for calendar-year organizations), which is also the initial filing deadline for the Form 990 for such year. (Transition rules are also provided for hospitals that complied with the CHNA requirements early.)

- **Other Section 501(r) requirements.** All of the Section 501(r) requirements other than the CHNA requirements are already in effect.

- **Effective date of Proposed Regulations and Transition Period.** The provisions of the Proposed Regulations will generally not be effective unless and until such provisions are published as final or temporary regulations. However, the Proposed Regulations may be relied upon for any CHNA conducted or implementation strategy

adopted on or before the date that is six months after the Proposed Regulations are published as final or temporary regulations, and the IRS's earlier guidance in Notice 2011-52 may be relied upon through October 5, 2013.

III. Key Issues Addressed in the Proposed Regulations

1. CHNA and Implementation Strategy Requirements

The Proposed Regulations are intended to be generally consistent with the IRS's previous guidance on CHNAs but with modifications and additional detail to reflect comments from the public received by the IRS and to promote flexibility and transparency in the CHNA process. Highlights include the following:

- **Definition of the "community" served.** For CHNA purposes, the community served by a hospital facility may be defined based on all relevant factors, without excluding medically underserved, low-income, or minority populations.

- **Limitation on the community health needs that must be covered.** Only "significant" community health needs must be addressed (instead of all such needs, as initially proposed).

- **Required input.** Input is required, at a minimum, from: (i) a state, local, tribal, or regional government public health department; (ii) members of medically underserved, low-income, or minority populations in the community or persons representing their interests; and (iii) any written comments received from the public on the most recent CHNA and implementation strategy.

- **Collaborative CHNAs and CHNA reports.** Although each hospital facility is generally required to conduct its own CHNA and issue its own CHNA report, a hospital facility may prepare its CHNA in collaboration with affiliated and/or unrelated hospital facilities (as well as government bodies and community organizations), and each such hospital facility's CHNA report may contain substantively identical information, if appropriate.

- **Joint CHNA reports.** If a hospital facility conducts a joint CHNA process with other hospital facilities, all of the collaborating hospital facilities may produce a joint CHNA report provided that all of the facilities define their community to be the same, the joint CHNA report clearly identifies each hospital facility to which it applies, and each hospital facility independently adopts the joint CHNA report.

- **Implementation strategies generally.** Implementation strategies must generally address how a hospital facility plans to address each significant health need identified through its CHNA or identify a health need as one that the hospital facility does not intend to address and the reasons why.

- **Joint implementation strategy.** Hospital facilities that adopt a joint CHNA report generally may also adopt a joint implementation strategy, provided that the joint implementation strategy clearly identifies each hospital facility, its particular role and responsibilities in taking the actions described in the implementation strategy, and the programs and resources that it plans to commit in taking those actions.

- **Public availability.** The CHNA is required to be made widely available to the public, including through a "conspicuous" website posting and making paper copies available.

- **Form 990 reporting.** Either the implementation strategy or a website link to it must be included in a hospital facility's Form 990. A hospital facility is also required to describe on its Form 990 the actions that it took during the year to address health needs identified in its most recent CHNA.

2. Hospitals Operated by Joint Ventures

The Proposed Regulations describe various circumstances under which a Section 501(c)(3) organization will be considered to operate a hospital facility for purposes of Section 501(r). In particular, a Section 501(c)(3) organization that participates in a joint venture that operates a hospital will not be subject to Section 501(r) if either:

(i) the organization does not have sufficient control over the joint venture to ensure that the hospital facility operates for Section 501(c)(3) purposes, and consequently treats the income from such hospital facility as subject to the unrelated business income tax; or

(ii) the organization entered the joint venture prior to the enactment of Section 501(r), does not have significant ownership or control over the joint venture to ensure compliance with Section 501(r), and satisfies certain other criteria.

3. Consequences of the Failure to Comply with CHNA and Other Section 501(r) Requirements

The Proposed Regulations provide much anticipated guidance regarding the consequences of failing to satisfy the CHNA and other Section 501(r) requirements. Highlights include the following:

- **Penalty for non-compliance with the CHNA requirements.** An excise tax of $50,000 is imposed for each hospital facility for each tax year in which it is not in compliance with the CHNA requirements.

- **Loss of tax exemption for non-compliance with the CHNA requirements and Section 501(r) generally.** Failure to comply with the CHNA or other

Section 501(r) requirements can cause revocation of Section 501(c)(3) tax-exempt status. The Proposed Regulations aim to provide a reasonable framework for imposing such drastic consequences, including:

- **Minor/inadvertent errors.** Minor or inadvertent errors that are due to reasonable cause and are corrected promptly after discovery will not be considered a failure to satisfy Section 501(r).

- **Errors that are not minor/inadvertent.** Errors that are not minor or inadvertent will be excused if they are not "willful or egregious" and if they are properly corrected and appropriately disclosed.

- **Income of a non-compliant facility is taxable.** The income from a hospital facility whose failure to comply with Section 501(r) is not excused will be treated as taxable. Detailed rules apply to calculating such tax.

- **Loss of tax exemption for non-compliance.** The fact that a legal entity operates a hospital facility that fails to comply with Section 501(r) and is treated as taxable will not necessarily cause revocation of the legal entity's Section 501(c)(3) tax-exempt status. The IRS will consider all relevant facts and circumstances in determining whether to revoke the entity's Section 501(c)(3) status, including the size, scope, and nature of the compliance failure, correction efforts, safeguards implemented to protect against future failures, etc.

- **Tax-exempt bond consequences.** The treatment of a hospital facility as non-compliant with Section 501(r) and therefore as taxable will not by itself affect the tax-exempt exempt status of bonds issued to finance the non-compliant hospital facility.

IV. Key Observations

- **Section 501(r) must be satisfied by each "hospital facility."** For organizations that operate multiple hospital facilities, a key feature is that the CHNA and other Section 501(r) requirements must be satisfied separately for each "hospital facility." The Proposed Regulations define a "hospital facility" generally as a facility required by a state to be licensed as a hospital, and provide that multiple buildings operated under a single state license are considered to be a single hospital facility.

- **Proposed definition of "hospital facility" may have unintended consequences.** State licensure laws may raise issues regarding the Proposed Regulations' definition of a "hospital facility" generally as a facility required by a state to be licensed as a hospital. For example, in New York, this definition may unintentionally include entities such as diagnostic and treatment centers and active parent organizations of a hospital, which are generally required to be licensed as hospitals under Article 28 of New York State's Public Health Law. A request for the IRS to clarify the definition could be made during the comment period for the Proposed Regulations.

- **Collaborations and joint CHNA reports are permitted.** The Proposed Regulations provide for the ability hoped for by multi-hospital systems and others to collaborate on the conduct of, and documentation process for, CHNAs and CHNA implementation strategies, which can help save significant time, expense, and personnel resources. However, the Proposed Regulations limit the circumstances under which collaborations and joint reports may be permitted, so they should be reviewed carefully to ensure compliance.

V. Next Steps

Section 501(c)(3) hospitals should already be in the process of conducting, or at least deep into the planning stages for, the CHNA process. The Proposed Regulations are highly detailed, and they should be reviewed carefully for possible comments and to be in a position to anticipate what may eventually be required for compliance if the Proposed Regulations become final. In particular, these efforts should be performed in coordination with efforts to comply with CHNA and other requirements on hospitals imposed at the state level, which may impose different burdens.

* * *

This Client Alert was authored by **Jay E. Gerzog** *and* **Tamar R. Rosenberg***. For additional information about the issues discussed in this Client Alert, or if you have any questions or seek assistance with preparing comments to the IRS, please contact one of the authors,* **Jeffrey H. Becker,** *or the Epstein Becker Green attorney who regularly handles your legal matters.*

If you would like to be added to our mailing list or need to update your contact information, please contact Lisa C. Blackburn at lblackburn@ebglaw.com or 202-861-1887.

ATLANTA
Robert N. Berg
Michael V. Coleman
J. Andrew Lemons
Kenneth G. Menendez
Marisa N. Pins
Evan Rosen
Alan B. Wynne

BOSTON
Barry A. Guryan

CHICAGO
Amy K. Dow
Griffin W. Mulcahey
Kevin J. Ryan

HOUSTON
Mark S. Armstrong
Daniel E. Gospin
Pamela D. Tyner

LOS ANGELES
Adam C. Abrahms
Dale E. Bonner
Ted A. Gehring
J. Susan Graham
Kim Tyrrell-Knott

NEW YORK
Nicholas S. Allison
Eric L. Altman
Jeffrey H. Becker
Vinay Bhupathy*
Michelle Capezza
Stephanie Carrington
Aime Dempsey
Sarah K. diFrancesca
Kenneth W. DiGia
Jerrold I. Ehrlich
James S. Frank
Arthur J. Fried
Paul A. Friedman
Jay E. Gerzog
John F. Gleason
Robert D. Goldstein
Wendy C. Goldstein
Robert S. Groban, Jr.
Gretchen Harders
Jennifer M. Horowitz
Kenneth J. Kelly
Joseph J. Kempf, Jr.
Jane L. Kuesel
Stephanie G. Lerman
Purvi Badiani Maniar
Wendy G. Marcari
Eileen D. Millett
Leah A. Roffman
Tamar R. Rosenberg
William A. Ruskin
Jackie Selby
Catherine F. Silie
Victoria M. Sloan
Steven M. Swirsky
Natasha F. Thoren

NEWARK
Joan A. Disler
James P. Flynn
Daniel R. Levy
Philip D. Mitchell
Maxine Neuhauser
Michael J. Slocum
Sheila A. Woolson

STAMFORD
David S. Poppick

WASHINGTON, DC
Kirsten M. Backstrom
Emily E. Bajcsi
Clifford E. Barnes
James A. Boiani
Selena M. Brady
George B. Breen
Lee Calligaro
Jesse M. Caplan
Jason E. Christ
Eric J. Conn
Tanya V. Cramer
Anjali N.C. Downs
Gregory H. Epstein
Steven B. Epstein
Ross K. Friedberg
Daniel C. Fundakowski
Brandon C. Ge
Stuart M. Gerson
David C. Gibbons
Shawn M. Gilman
Jennifer K. Goodwin
Daniel G. Gottlieb
Philo D. Hall
Douglas A. Hastings
Robert J. Hudock
William G. Kopit
Amy F. Lerman
Christopher M. Locke
Katherine R. Lofft
Julia E. Loyd
Mark E. Lutes
Kara M. Maciel
Benjamin S. Martin
Teresa A. Mason*
David E. Matyas
Colin G. McCulloch
Frank C. Morris, Jr.
Leslie V. Norwalk
Kathleen A. Peterson
Daniela A. Pirvu
René Y. Quashie
Jonah D. Retzinger
Serra J. Schlanger
Bonnie I. Scott*
Deepa B. Selvam
Alaap B. Shah
Lynn Shapiro Snyder
Adam C. Solander
Ophir Stemmer
David B. Tatge
Daly D.E. Temchine
Bradley Merrill Thompson
Carrie Valiant
Patricia M. Wagner
Robert E. Wanerman
Constance A. Wilkinson
Kathleen M. Williams
Lesley R. Yeung

**Not Admitted to the Practice of Law*